Seattle City Light

CERTIFICATE OF MEDICAL EMERGENCY

Physician's Statement (Check One):

☐ **I certify** that the person listed below uses **recognized life support equipment** requiring an electrical connection and that the termination of electrical service to their residence would create a **life-threatening situation**.

OR

☐ **I certify** that the person listed below has a **health-threatening situation** involving a **temporary** illness or condition in which loss of electrical service could result in prolonging or exacerbating the illness or suspected illness.

Please complete the following:

1. Person's Name:_____
2. Person's Address: _____
3. Person uses the following life support equipment requiring an electrical connection:
   (Check ALL that apply)
   - ☐ VENTILATOR (Continuous Mechanical)
   - ☐ OXYGEN Concentrator (Does not include liquid or cylinder oxygen use)
   - ☐ DIALYSIS (In-home Peritoneal Dialysis only)
   - ☐ CPAP or BIPAP device
   - ☐ NEBULIZER
   - ☐ SUCTIONING Device
   - ☐ DISPENSER (Feeding Pump or Medication Dispenser)
   - ☐ BED-MATTRESS (Electric hospital bed or alternating pressure mattress)
   - ☐ CHAIR (Electric lift chair or electric wheelchair, rechargable)
   - ☐ OTHER Life Support Equipment (Please specify type): _____
   - ☐ HEATING/COOLING (Patient is vulnerable to extreme temperatures due to serious long-term medical condition and patient's health will be significantly endangered by the termination of electrical service for heating/cooling).
4. Person's use of life support equipment is expected to be: (**Check one**)
   ☐ Short-term (Less than 60 days) ☐ Long-term (More than 60 days)
5. For temporary health-threatening situation NOT involving life support equipment, explain how the health of the person will be significantly endangered by the loss of electrical service:_____
   _____
   _____

Signature of Licensed Physician_____

Physician's I.D. Number _____Date _____

Name (Please Print) _____Phone _____

Address _____

City Light Customer's Statement

The person named in this Certificate who uses electric-powered life support equipment is a permanent resident at the service address shown below.

I understand that this Certificate does not relieve the customer of the obligation to pay for electrical service. I understand that where the use of life support equipment is documented by this Certificate, the extension of electrical service for nonpayment will be determined on an individual basis and will not exceed 30 days. I also fully understand that electrical service may be terminated for failure to make agreed upon payment.

I understand that this Certificate is valid only for the length of time the life or health endangerment is certified to exist and that it is not valid for more than one year without renewal.

Customer Name: _____

Service Address: _____

Customer Signature: _____ Date: _____

Statement of Person Using Life Support Equipment

The information I have provided to the licensed physician is true, and I authorize the release of information on this certificate to Seattle City Light.

Name (print): _____

Signature: _____ Date:_____

Relation to Person Using Life Support Equipment (**Check one**):

☐ Self ☐ Spouse ☐ Parent or Guardian ☐ Agent with Power of Attorney

☐ Other please specify): _____

Please list all phone numbers and your e-mail address and check the box next to your preferred method(s) of contact:

- ☐ Home Phone: _____
- ☐ Work Phone: _____
- ☐ Cell Phone: _____
- ☐ Message Phone: _____
- ☐ Emergency contact number: _____
- ☐ Other: _____
- ☐ E-mail Address: _____

MAIL Completed Certificate to:
Seattle City Light Credit Office, P.O. Box 34023, Seattle, WA 98124-4023

OR FAX to: Seattle City Light Credit Office at (206) 233-3748